



**UNIVERSITY HEALTH SERVICES (UHS)
SPORTS PRE-PARTICIPATION MEDICAL HISTORY**

Date	Print Name (Last, First)	Penn State Student ID Number	DOB
------	--------------------------	------------------------------	-----

Athletes Medical Questionnaire:

Yes No Circle questions to which you don't know the answer. Explain "Yes" answers below.

- 1. Have you had a medical illness or injury since your last checkup or sports physical?
- 2. Have you ever been hospitalized overnight?
- 3. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler?
- 4. Have you taken any supplements or vitamins to help you gain or lose weight or improve your performance?
- 5. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?
- 6. Have you ever passed out during or after exercise?
- 7. Have you ever been dizzy during or after exercise?
- 8. Have you ever had chest pain during or after exercise?
- 9. Do you get tired more quickly than your friends do during exercise?
- 10. Have you ever had racing of your heart or skipped heartbeats?
- 11. Have you ever been told you have a heart murmur?
- 12. Has any family member or relative died of heart problems or of sudden death before age 50?
- 13. Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the past month?
- 14. Has a physician ever denied or restricted your participation in sports for any heart problems?
- 15. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?
- 16. Have you ever had a head injury or concussion?
- 17. Have you ever been knocked out, become unconscious, or lost your memory?
- 18. Have you ever had a seizure?
- 19. Do you have frequent or severe headaches?
- 20. Have you ever had numbness or tingling in your arms, hands, legs, or feet?
- 21. Have you ever had a stinger, burner, or pinched nerve?
- 22. Have you ever become ill from exercising in the heat?
- 23. Do you cough, wheeze, or have trouble breathing during or after activity?
- 24. Do you have asthma?
- 25. Do you have seasonal allergies that require medical treatment?
- 26. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotic, retainer on your teeth or hearing aid)?
- 27. Have you had any problems with your eyes or vision?
- 28. Have you ever had a sprain, strain, or swelling after injury?
- 29. Have you broken or fractured any bones or dislocated any joints?
- 30. Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?
If yes, check appropriate box and explain below:
 Head Elbow Thigh Neck Forearm Knee Back Wrist Hip
 Shin/Calf Chest Hand Ankle Shoulder Finger Foot Upper arm
- 31. Do you want to weigh more or less than you do now?
- 32. Do you lose weight regularly to meet weight requirements for your sport?
- 33. Do you feel stressed out?

34. What are the dates of your most recent immunizations (shots) for:
 Tetanus? _____ Measles? _____ Hepatitis B? _____ Chickenpox? _____

Females Only

- 35. When was your first menstrual period? _____ When was your most recent menstrual period? _____
- 36. How much time do you usually have from the start of one period to the start of another? _____
- 37. How many periods have you had in the past year? _____

Explain "Yes" answers here:

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete: _____ Date: _____